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ABSTRACT

Intended for personnel in programs serving persons with developmental disabilities, the booklet provides basic information about the major psychiatric disorders and their treatment. Five sections cover: the major disorders; medications--uses and problems; assessment; cooordination of services; and psychiatric emergencies. Major disorders such as schizophrenia and affective illness, bipolar disorder, and depression are described. Commonly used antipsychotic and antidepressant medications are listed by both generic and trade names, and side effects are explained. Four steps of assessment are recommended: (1) obtain informed consent from the client or guardian; (2) obtain medical and psychiatric history; (3) obtain a social history; and (4) obtain verification that the client has had a recent physical examination. Coordination of services including those of a physician, a therapist, a source of expert information on medications, and an inpatient facility is urged. Finally, appropriate immediate management of a psychiatric emergency is discussed. Six references. (DB)

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Monograph #101

A Psychiatric Primer for Programs Serving People with Developmental Disabilities

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INTRODUCTION

This primer is designed to provide basic information about the major psychiatric disorders and their treatment. The information should be useful to programs serving persons with developmental disabilities and other individuals interested in service provision. The primer consists of five sections:

I. The Major Disorders
II. Medications: Uses and Problems
III. Assessment
IV. Coordination of Services
V. Psychiatric Emergencies

SCHIZOPHRENIA AND AFFECTIVE ILLNESS

Suppose that a client has been called psychotic or has been given a diagnosis of schizophrenia or bipolar disorder - what does this mean? Psychosis is a general term used to describe gross impairment of a person's ability to recognize reality and respond appropriately to his or her environment. Psychotic symptoms include delusions and hallucinations. Delusions are ideas that have no basis in reality. Hallucinations are usually auditory but may involve any sensory modality. Two illnesses, schizophrenia and bipolar disorder, are often considered to be functional psychoses, to differentiate them from psychoses resulting from a medical illness, which are called organic psychoses. Descriptive diagnosis currently rests on classifications presented in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM III) 1980.*

Schizophrenia

Schizophrenia involves all areas of psychological functioning: the form and content of thinking, perception, feelings and behavior. The onset of the illness is usually during adolescence or early adulthood. In order to make a diagnosis of schizophrenia, symptoms must appear prior to the age of forty-five. The severity of symptoms is variable. At times, they may be barely detectable; at other times they are extreme and interfere with the safety of the client. On first meeting the client, there may be a vague sense of discomfort or confusion. This usually results from the client's manner of thinking and relating. He or she has difficulty organizing thoughts and ignoring extraneous, irrelevant or tangential information or associations. Although calmly presented, a confusing, illogical, disorganized monologue that seems to have little to do with the topic at hand reflects loose associations - perhaps the first clue to the presence of schizophrenia.

Delusions are another symptom of this illness. The client could be convinced, for example, that he/she is Jesus Christ, that everyone wants to follow him/her, or that food or water is poisoned. Delusions can cause the client to be frightened of others and their intentions, resulting in a strong reluctance to talk about these ideas with anyone. Behavioral signs of the presence of such thoughts may include increasing agitation, fearfulness, and even aggression.

Hallucinations are also common in this illness. The voices are experienced as real and as coming from outside - not from within. Command hallucinations, such as hearing a command to kill oneself, are obviously the most serious. Clients may not talk openly about hearing voices, but may be observed talking to themselves or appearing to carry on conversations with others when no one is around.

The schizophrenic client can exhibit a disturbance of affect. He or she may show no emotion, or appear shallow or distant. Alternatively, he or she may express bizarre or inappropriate emotion, such as giggling when discussing some routine matter.

The following table adapted from DSM III outlines specific diagnostic criteria:

TABLE I

A. At least one of the following during an active phase of the illness:
   1. Bizarre delusions, such as delusions of being controlled, though broadcasting, thought insertion, or thought withdrawal.
   2. Somatic, grandiose, religious, ni-

hilistic, or other delusions without persecutory or jealous content.

3. Delusions with persecutory or jealous content if accompanied by hallucinations of any type.
4. Auditory hallucinations in which either a voice keeps up a running commentary on behavior or thoughts, or two or more voices converse with each other.
5. Auditory hallucinations on several occasions with content of more than one or two words, having no apparent relation to depression or elation.
6. Incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech if associated with at least one of the following:
   a. Blunted, flat or inappropriate affect.
   b. Delusions or hallucinations.
   c. Catatonic or other grossly disorganized behavior.

B. Deterioration from a previous level of functioning in such areas as work, social relations and self-care.

C. Duration: continuous signs of the illness for at least six months at some time during the person's life, with some signs of the illness at present. The six-month period must include an active phase during which there were symptoms from A, with or without a prodromal or residual phase.

Those who have experienced working with developmentally disabled clients know that there are those who may manifest any one of these symptoms without being schizophrenic. Some clients, for example, appear to need to talk to themselves, providing additional structure in approaching a new task; there are those who scold themselves in a way they may have experienced in childhood. The presence of these behaviors does not automatically indicate this psychiatric diagnosis. However, if a client has undergone a formal, professional evaluation and the diagnosis of schizophrenia has been made, this constellation of symptoms is characteristic.

The best prognosis is associated with the most favorable history. Ability to go to school and sustain long-term relationships are indicators of a good prognosis. Insidious onset at a young age with a history of inability to work, homelessness, poor relationships with family or friends, and inability to engage in treatment are unfavorable indicators. Although the picture for the extremely ill patient is bleak, there are those who manifest less-severe symptomatology and are able to engage in programs successfully.

Program staff who observe a client displaying increased suspiciousness, isolation, an increase in talking when no one is present, irritability and aggression may want to request a formal psychiatric or psychological evaluation.

Bipolar Disorder

This disorder is characterized by the presence or history of at least one manic episode and is one of the most difficult diagnoses to make in the developmentally disabled population because the presentation frequently is muted. The following describes the typical findings in the general population. The age of onset is usually between the ages of 25 and 55 with a peak age of onset of 30. Whereas the schizophrenic client may be withdrawn, isolative and preoccupied with delusions, the manic is classically hyperactive, exhibiting a flamboyant and enthusiastic manner, engaging others rapidly and perhaps intrusively. Bizarre, colorful clothing, or excessive make-up attract attention. He or she talks loudly, rapidly and intently, going from topic to topic with little opportunity for anyone else to speak. S/he exhibits a contagious euphoric or irritable mood. Increased activity accompanied by a marked decrease in need for sleep is common.

The hyperactivity of mania occurs in the context of very poor judgment: spending sprees, gambling, indiscriminate or excessive sexual activity with little or no appreciation of the consequences of such behavior. The manic person feels so grandiose that there is denial of the pos-

sibility of ill effects resulting from behavior. Grandiosity associated with mania is sometimes intertwined with delusions of power and importance. Delusions are not always grandiose; paranoid or persecutory delusions are also possible. If the person is also hallucinating, this psychotic constellation is difficult to differentiate from an acute exacerbation of schizophrenia.

The expansive, euphoric mood that seems to elevate everyone is likely to be extremely labile. A sudden switch to irritability and mistrust in a hyperactive, pressured patient can happen at any time and create a dangerous situation.

For the developmentally disabled person, the key symptoms of this disorder may present in such a way as to be unrecognizable as mania under other circumstances. For example, the delusions of grandeur may be expressed as a sudden wish to buy a car or go to college. The client with this diagnosis should be observed for excessive, non-sensical talking, an increase in distractibility, an inability to sit still and attend to the task, not sleeping, irritability, aggression, and new conversational themes of unattainable goals.

Unlike schizophrenia, there is no requirement that symptoms be present for six months to make the diagnosis. Manic symptoms must be present for at least one week, and, in fact, may alternate or intermix with symptoms of depression. The number of manic episodes a client experiences in a lifetime is variable. Some severely afflicted individuals may experience several episodes within a year. Others have only two or three episodes in a lifetime. The latter pattern is more common. When the manic episode is over, the person typically returns to his or her usual level of functioning; an important contrast to schizophrenia.

The following table outlines DSM III criteria for a manic episode:

TABLE 2

A. One or more distinct periods with a predominantly elevated,expansive, or irritable mood. The elevated or irritable mood must be a prominent part of the illness and relatively persistent, although it may alternate or intermingle with depressive mood.

B. Duration of at least one week (or any duration if hospitalization is necessary), during which, for most of the time, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   1. Increase in activity (either socially, at work, or sexually) or physical restlessness.
   2. More talkative than usual or pressure to keep talking.
   3. Flight of ideas or subjective experience that thoughts are racing.
   4. Inflated self-esteem (grandiosity, which may be delusional).
   5. Decreased need for sleep.
   6. Distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli.
   7. Excessive involvement in activities that have a high potential for painful consequences which is not recognized, e.g., buying sprees, sexual indiscretions, foolish business investments, reckless driving.

C. Neither of the following dominate the clinical picture when an affective syndrome (i.e. criteria A and B above) is not present, that is, before it developed or after it has remitted:
   1. Preoccupation with a mood-incongruent delusion or hallucination.
   2. Bizarre behavior.

D. Not superimposed on either Schizophrenia, Schizophreniform Disorder, or a Paranoid Disorder.

E. Not due to any Organic Mental Disorder, such as Substance Intoxication.

Depression

A manic episode can be followed by an episode of depression. Depression in a bipolar patient deserves the same attention as in a patient

with a diagnosis of unipolar depression. The client may not complain of depression, therefore the diagnosis may be made from observations of problems sleeping, lack of appetite, lack of energy, disinterest in any activities, or multiple worries about health. The client just can't seem to get involved in his or her routine as he or she could in the past. None of these symptoms alone add up to a diagnosis of depression. However, when these complaints are accompanied by pervasive feelings of hopelessness, sadness, worthlessness and apathy, depression must be considered. Tearfulness and sighing convey the depth of painful emotion. Suicide is the lethal complication of depression, and a client who talks of wishing to go away forever or to be dead must be taken seriously and help sought.

A major depression can be accompanied by psychotic symptoms, i.e. delusions and hallucinations. Therefore, clients who are known to be suffering from this illness should be observed for the presence of these additional symptoms.

The following table outlines DSM III criteria for a diagnosis of a Major Depressive Episode:

TABLE 3

A. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes. The dysphoric mood is characterized by symptoms such as the following: depressed, sad, blue, hopeless, low, down in the dumps, irritable. The mood disturbance must be prominent and relatively persistent, but not necessarily the most dominant symptom, and does not include momentary shifts from one dysphoric mood to another dysphoric mood, e.g., anxiety to depression to anger, such as are seen in states of acute psychotic turmoil.

B. At least four of the following symptoms have each been present nearly every day for a period of at least two weeks:
   1. Poor appetite or significant weight loss (when not dieting) or increased appetite or significant weight gain.
   2. Insomnia or hypersomnia.
   3. Psychomotor agitation or retardation (but not merely subjective feelings of restlessness or being slowed down).
   4. Loss of interest or pleasure in usual activities, or decrease in sexual drive not limited to a period when delusional or hallucinating.
   5. Loss of energy; fatigue.
   6. Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt (either may be delusional).
   7. Complaints or evidence of diminished ability to think or concentrate, such as slowed thinking, or indecisiveness not associated with marked loosening of associations or incoherence.
   8. Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attempt.

C. Neither of the following dominate the clinical picture when an affective syndrome (i.e., criteria A and B above) is not present, that is, before it developed or after it has remitted:
   1. Preoccupation with a mood-incongruent delusion or hallucination.
   2. Bizarre behavior.

D. Not superimposed on either Schizophrenia, Schizophreniform Disorder, or a Paranoid Disorder.

E. Not due to any Organic Mental Disorder or Uncomplicated Bereavement.

Clients suffering from any of the illnesses discussed above can have psychotic symptoms. However, these are not the only illnesses that present with psychosis and the evaluation of such symptoms *requires a complete medical assessment*, particularly the first time they come to the attention of health care providers. Physicians usually evaluate the client for medical illnesses that may be causing the symptoms, including: drug or alcohol intoxication or withdrawal, infections, metabolic and endocrine abnormalities, brain tumor, head trauma, nutritional deficien-

cies, lack of oxygen to the brain, epilepsy and other neurologic conditions.

The range of psychiatric disorders seen in the developmentally disabled population is certainly not limited to the three described above. Clients may suffer from a brief psychotic reaction resulting from a clear stress in their lives, without being either schizophrenic or manic. In addition, there are disorders that have symptoms of irritability and aggression, such as Intermittent Explosive Disorder. Anxiety disorders, personality disorders, and substance abuse disorders can also be found in this population. The illnesses described above have been discussed because they are more likely to be chronic or recurring and result, at times, in significant impairment. In addition, they often require ongoing therapeutic intervention, including medication. Medications used to treat these illnesses may have side effects that can impair performance.

MEDICATIONS: USES AND PROBLEMS

Antipsychotic medications, also known as neuroleptics, have been shown to be an efficacious treatment of schizophrenia and are often used for acute exacerbations of mania or depression when psychotic symptoms are present. They should not be used in the absence of a valid psychiatric diagnosis. This class of medication includes:

Chlorpromazine	(Thorazine)
Thioridazine	(Mellaril)
Fluphenazine	(Prolixin)
Haloperidol	(Haldol)
Fluphenazine	(Prolixin Decanoate)
Thiothixene	(Navane)
Perphenazine	(Trilafon)
Loxapine	(Loxitane)
Trifluoperazine	(Stelazine)
Molindone	(Moban)
Mesoridazine	(Serentil)

Any patient treated with these medications should be monitored by a physician for side effects. The most common are extrapyramidal symptoms, acute dystonic reactions, akathisia, hypotension and sedation. Extrapyramidal side effects are characterized by slow, stiff movement - the client might look very rigid, walk slowly and perhaps shuffle his feet. In addition, he might have a tremor that is seen as shaking and unsteady movement in the hands. An associated hand movement, repetitively rubbing the thumb and forefinger together, is also sometimes observed. Often this side effect can be treated with the addition of another class of medication. Frequently, the medication used to treat the side effect can be withdrawn at a later time.

Dystonic reactions sometimes occur shortly after beginning treatment with antipsychotics and consist of the sudden appearance of odd contortions of the head and neck. The client's face may become twisted into a grimace; one of her shoulders may be pulled up against her neck and cheek. When this side effect occurs, it is often frightening to the individual and to those who observe it. The client's doctor should be notified immediately since treatment will readily reverse this condition.

Akathisia is a subjective sensation of restlessness which may or may not be observable, but is often quite uncomfortable for the patient. Treatment of this side effect has variable success. If a client suffers from akathisia, sitting at his work station for prolonged periods of time may be unbearable and behavioral approaches will be of no value. If this is the case, the physician should be notified and a medication change considered.

Tardive dyskinesia is usually a late-appearing complication of antipsychotic treatment. Not everyone who takes an antipsychotic medication gets tardive dyskinesia; however, for those who do, the symptoms can have serious implications. This syndrome is the primary reason that long-term use of antipsychotics is strongly discouraged. For those who do require long-term exposure to antipsychotics, regular medical follow-up is essential. Symptoms include involuntary writhing movements of the tongue and lips. There may be similar writhing movements in the hands, particularly when the client is not busy using her hands. The fact that these move-

ments are involuntary means that the client is not controlling them consciously. The treatment for this condition is to lower the dose of the antipsychotic medication and stop it. Paradoxically, the client's symptoms may get much worse before they get better, and not everyone with tardive dyskinesia gets better. Therefore, communication with the physician involved is important during this phase of treatment. Usually, the client will be able to continue work, as long as those involved in training do not demand quiet hands or sitting completely still. An additional serious problem is that psychotic symptoms may resume when the medication is tapered and discontinued, another reason to have a good line of communication with the treating physician.

An additional potential side effect of some of the antipsychotic medications is dizziness. This usually only occurs if the client stands up too quickly. Simple reminders not to do this are often all that is needed; however, in some circumstances, this side effect is disabling and a medication change is required.

Additional side effects of antipsychotic medications include: sedation, dry mouth, urinary retention, increased appetite, constipation, breast enlargement and milk secretions, changes in menstrual cycle and sexual functioning, changes in liver functioning, and lowered white cell blood count.

A rare but life-threatening side effect is neuroleptic malignant syndrome (NMS). NMS is characterized by fever, muscle rigidity, tremors, instability of blood pressure and heart rate, and changes in thought and perceptions. Any suspicion that a client is suffering from NMS warrants emergency medical attention.

For clients suffering from a seizure disorder it should be noted that antipsychotic medications lower seizure threshold, some more than others, thereby making seizures more likely.

Common antidepressant medications include the following:

Generic:	Amitriptyline	Trade:	(Elavil) (Endep) (Amitril)
Generic:	Desipramine	Trade:	(Norpramin) (Pertrofrane)
Generic:	Trimipramine	Trade:	(Surmontil)
Generic:	Nortriptyline	Trade:	(Pamelor) (Aventyl)
Generic:	Doxepin	Trade:	(Sinequan) (Adapin)
Generic:	Protriptyline	Trade:	(Vivactil)
Generic:	Maprotiline	Trade:	(Ludiomil)
Generic:	Imipramine	Trade:	(Tofranil) (Presamine) (Antipress) (Imavate) (Janimine)
Generic:	Amoxapine	Trade:	(Asendin)

These medications have been shown to be useful in the treatment of depression; however, two to three weeks must pass after initiation of treatment to begin to observe therapeutic effects. Common side effects associated with antidepressants include dry mouth, blurred vision, dizziness, constipation and, in some cases, urinary retention. Antidepressants can also lower seizure threshold. Antidepressants can be lethal in cases of overdose. Conservative practice dictates that the physician will usually not prescribe more than a two-week supply at any given time if the client is in charge of his medication and not monitored. Any suspicion that a client is stockpiling medication instead of taking it is therefore alarming, and the physician should be notified (Goodman and Gilman, 1980).

Lithium is an important mood-stabilizing medication useful in the treatment of bipolar disorder. Side effects associated with lithium therapy include tremor and upset stomach, particularly if the medication is taken on an empty stomach. Rarely, lithium treatment may lead to frequent

urination, indicating an underlying kidney problem resulting from therapy. Also, rarely, thyroid problems may emerge. If the client is taking too much lithium, she may become quite confused, disoriented, and clumsy in efforts to walk; therefore, physicians usually follow blood levels of this medication on a regular basis.

Extreme toxicity can result in persistent vomiting, diarrhea, and weakness as well as seizures and coma. Conversely, and this case is more common, those who are not reliable about taking the medication may have subtherapeutic blood levels and be receiving no benefit. The very symptoms for which the person is taking lithium may contribute to his unwillingness to do so, i.e., grandiosity, poor judgment and inability to size up consequences of behavior. The client feels he or she can handle things without medication and, therefore, avoids its use. When noncompliance is evident, explorations for underlying reasons should include this avenue since, in general, the medication itself produces few side effects. Clients taking lithium should be strongly encouraged to keep their doctor's appointments and to stay current on their medication monitoring. If symptoms associated with intake of too much lithium occur, the prescribing physician should be notified at once.

ASSESSMENT

Psychiatric illness can be acute or chronic. Acute psychiatric symptoms may be the result of a recent emotional upset in a client's life, drug or alcohol intoxication or withdrawal, a consequence of an underlying medical illness, a side effect of pharmacological treatment for a medical illness, or the first appearance of a chronic psychiatric illness. Chronic psychiatric symptoms are often associated with long-term disorders such as: 1) schizophrenia, and 2) affective illness. Performance at work and at home can be affected by these disorders in a variety of ways. Therefore, from the beginning, the service program should have access to information regarding a client's medical or psychiatric diagnosis, the course of the illness, and treatment. Such knowledge can assist the staff in developing appropriate goals and observing for changes in function that may be illness related, thus better serving the client's short- and long-term needs.

Assessment is based on the goal of getting to know the client where he lives, who he cares for and who cares for him, and a knowledge of his medical or psychiatric limitations. This information, in addition to a description of the client's developmental disability, program history, and skills assessment, can provide a complete data base upon which realistic planning can begin. The following is a specific outline for obtaining the necessary information. Obtaining this information requires the client's or guardian's consent and this should be the first step.

I. Obtain informed consent for obtaining medical and psychiatric history.

This may be performed by the case manager or other authorized person referring the client for assistance. Do not proceed if consent is unavailable.

II. Obtain medical and psychiatric history.

A. List medical and psychiatric illnesses from which the client suffers; include the cause of the client's developmental disability if this is known.
B. How long has the client had the illness?
C. Does anyone in the client's family suffer from medical or psychiatric illness?
D. Does the client use street drugs or alcohol? If the answer is yes, find out the type of substance used, the frequency of use and the degree of impairment.
E. How may hospitalizations has this client had related to the illness? When was the most recent one?
F. Who treats the client for these illnesses?
G. What symptoms might be seen in our program related to this illness?
H. Is the client receiving any medications? If so, list the medication, the dose, the illness for which it is being prescribed, and the

professional monitoring the effects of the medication.

I. Has the client had any side effects from the medication?
J. Have there been any changes in the individual's medication in the recent past?
K. Is there any use of PRN or STAT medications?
L. Who should be contacted in case of an emergency?
M. Is the client allergic to any foods or medications?

The best source of information for most of the answers is the client's treating physician or psychiatrist. The answers to these questions hold clear implications for day-to-day functioning. A developmentally disabled client who suffers from severe bipolar disorder poorly controlled with medication may require several hospitalizations a year because of disabling symptoms. Conversely, a developmentally disabled client with the same diagnosis may have experienced only two or three episodes requiring hospitalization, and these occurred many years in the past. This client may get a good response from medication and be compliant with ongoing treatment, predicting little disruption in daily functioning.

Because it is not routine for the staff of developmental disabilities programs to be familiar with symptoms associated with psychiatric illness, the answer to question "G" is extremely important. Symptoms should be described clearly and in terms that make it possible for staff to observe for them. In addition, make note of any suggestions made for effective intervention with the symptoms. For example, if the response to the question is: "Oh, John does pretty well, but he has ongoing auditory hallucinations and paranoid delusions which really don't get in his way." Ask for clarification: "Can you tell me a little more about that? Exactly what does John do?" An acceptable response might be: "Well, sometimes when he's doing something, he'll mutter to himself, as if he were talking to someone who isn't there. It only happens occasionally and if you divert his attention a little, he stops. He also may be somewhat withdrawn in social situations and appear suspicious if you ask what he's thinking about. You see, he's always had this idea that the CIA has tried to control his life. It's usually best to let him warm up to people on his own."

III. Obtain a social history.

A. Where does the client live?
B. With whom does s/he live? Does s/he get along well in this setting?
C. How does the client currently spend his or her day?
D. If s/he does not live with family, where are they, and are they actively involved with the client?
E. Is the client his or her own legal guardian?
F. Has the client ever exhibited violent behavior? Hurt anyone? Been arrested?
G. Does the client engage in sexually inappropriate behavior?
H. Does the client exhibit any behaviors in his or her current situation that may be problematic in the new program?
I. What is the client's educational background? Can s/he read and write? Are there specific learning disabilities we need to know about?

From this simple set of questions, one can usually ascertain the client's relationship with the family of origin, whether he/she is married, what his/her legal status is, the existence of any inappropriate behaviors that may have been observed in another setting as well as further information about learning difficulties.

IV. Obtain verification that the client has had a recent physical examination.

This is a standard requirement for acceptance into any service program. Patients with dual diagnoses are obviously not immune from developing high blood pressure, heart disease, hearing problems, or other ailments. Having baseline information regarding the client's physical condi-

tion is essential in terms of assessing degree of physical limitation and planning for appropriate types of activity.

Although this may seem to be an extensive amount of information to gather, it provides the kind of data that can circumvent later problems and help a client's program proceed more smoothly. It also can be synthesized into a brief narrative that may be presented at initial review conferences and be invaluable in the determination of an appropriate program. The following is an example of the way such a narrative might be presented.

Today we are considering Ms. Sue Jones for acceptance into our program. Ms. Jones is a 22 year old, single woman, who has always lived with her parents in this city. Her parents are relatively young and in good health. Ms. Jones suffered from a head injury in an automobile accident when she was three years old and has functioned in the moderately mentally retarded range since that time. Ms. Jones also had an injury to her right leg in the accident and she requires a leg brace. This is the first time that her parents have sought training for her and are a little nervous about letting her leave home. They are concerned, however, about their daughter simply sitting at home, spending most of her time watching television.

When Ms. Jones was 18 years old, she exhibited extreme social withdrawal, began to hear voices, and to strike out at people around her. She was hospitalized and diagnosed as having schizophrenia. Dr. Smith, her psychiatrist, has followed her since that time, and she has required no further hospitalizations. She takes medication for this illness, haloperidol, 5 mg. per day. Because her doctor is concerned about long-term side effects, he has been gradually decreasing her dose and is aiming at following her on even a lower dose, or no medication at all. Thus far, she has had no side effects. She continues to be a fairly quiet and withdrawn person, at times giggling to herself, but she is not violent around others.

Her mother is worried about Ms. Jones coming to our program because she has had problems in the past when she has been in a new environment. She tends to become suspicious of others. Once, when she stayed overnight with a relative, she hid on the floor in a corner with a blanket wrapped around herself and refused to talk with anyone until her mother came and got her. In contrast to this behavior, we know she was able to attend special education classes until she was 20 and was able to do this successfully without her mother's presence. Her mother also states that Ms. Jones is sometimes seductive around males and will approach strangers asking for pop or cigarettes. These behaviors concern her mother when she considers Ms. Jones taking public transportation to work.

COORDINATION OF SERVICES

Effective coordination of services is a necessity for anyone with a developmental disability. When someone with a developmental disability also has a psychiatric disorder, the need for effective coordination is even more acute. In addition to whatever vocational and community living services the individual needs, the following should also be in place:

1) A physician who monitors all medication levels and effects on a regular basis.
2) A therapist who can answer questions for service providers, such as how concerned should I be about X behavior or how should I respond to a manic episode. This person may be part of a regular service program or a consultant to it, and may be a psychologist, psychiatrist, social worker, or other trained therapist.
3) A source of expert information on medications, their interactions, and side effects.
4) An inpatient facility which can handle psychiatric emergencies.
5) Enough flexibility in funding and administrative structures to allow programs to hold spots open for dually diagnosed persons having difficult episodes. For instance, the ability for a group home to keep a bed open for someone who is tem-

porarily hospitalized, or the ability of an employment program to tolerate increased wandering during a manic episode.

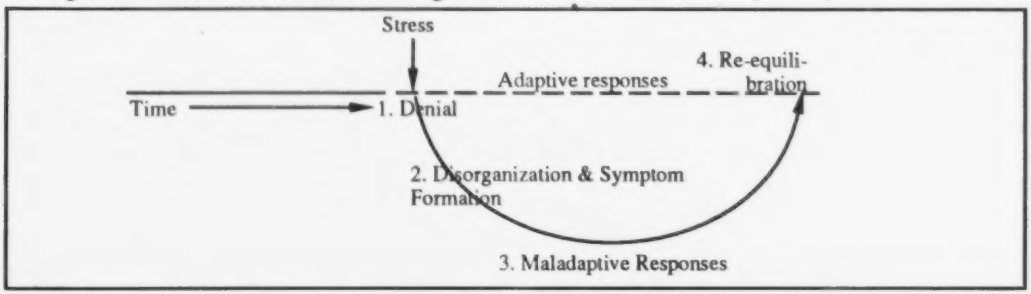
6) Enough behavioral expertise on the part of service providers to maintain and improve the effective functioning of those served. This component is absolutely essential. There has been evidence for years that psychiatric treatment alone is not sufficient to meet the needs of those with psychiatric disorders and that behavioral treatment can make a significant difference (e.g. Paul & Lentz, 1977). This is true for two reasons: 1) symptoms with an organic etiology can often be controlled environmentally; and 2) for people who have been institutionalized for any length of time, the effects of institutionalization are often just as debilitating as the original reason for institutionalization.

EMERGENCIES

A psychiatric emergency can occur when a client experiences a stress which is beyond his ability to cope in a positive way. The client is overwhelmed, out of control, and resulting behavioral responses can lead to injury of self or others. There are a myriad of problems associated with dual diagnoses that can leave a client feeling frustrated and unable to cope: limited ability to problem-solve, poor self-esteem, problems related to communication, particularly if speech is impaired, and underlying neurologic dysfunction. If the client also has a history of having been abused as a child, or having witnessed abuse, there is an even greater risk for responding in a maladaptive or dangerous manner to stress, as if judgment is impaired due to alcohol or drugs. If the client has access to weapons during an emergency, a dangerous situation can become a lethal one.

Everyone responds to stress in a way designed to re-establish psychological equilibrium. Understanding the normal stress-response pattern provides a framework for understanding desperate maladaptive responses that result in dangerous behaviors. A stress is defined as anything that threatens self-esteem and triggers fears of loss or failure. Phasic responses to stress include (Weissberg, 1983): 1) denial, 2) symptom formation, 3) maladaptive or adaptive response, and 4) re-equilibration. For example, if a young man is turned down after applying for a job, his first response might be denial or disbelief: "I can't believe they won't give me that job!" The period of symptom formation is characterized by disorganization, anxiety, or anger: "What am I going to do now? Maybe I'm really useless; I'll never make my way in this world." or, "Boy, those guys will be sorry when I own that company and the all get fired. They'll see. That application process wasn't fair to begin with." Kicking the door on the way out of the building or several nights' loss of sleep are maladaptive responses that may precede a period of re-quilibration characterized by problem solving. The diagram below outlines this response pattern (Weissberg, 1983).

Emergencies appear to happen out of nowhere. All of a sudden, a client starts screaming and threatening others, or picks up a chair and throws



it at someone, or climbs out on the fire escape and threatens to kill himself. The period of acute danger is often brief, a few minutes to a few hours. The key to management of a potentially dangerous situation is to try to pick up on the situation at some point before a maladaptive response occurs; that is, being mindful of potential *stresses* and watching for the *denial* and *disorganization* phases. This simply isn't always possible. Therefore, the process of analyzing an emergency often happens after it has occurred and is essential to preventing a recurrence.

The balance between one's ability to think and solve problems in a constructive manner and one's emotional state can be limited when stresses intensify or become more frequent. Common stresses usually involve loss and can take the form of loss of something or someone, loss of function or ability, or loss of a way of seeing one's self resulting in diminished self-esteem. For the developmentally disabled, and particularly those with a psychiatric diagnosis, any of these stresses may put a serious strain on psychological and emotional balance. Changes in work stations, staffing patterns, schedules, transportation, expectations, living situation, or in an important relationship can leave a client feeling more vulnerable. Depending on the client's ability to express concern and the availability of others to be helpful, the client can have an easier or more difficult time. Of course, these examples of changes don't necessarily lead to an emergency. But, they could represent a background level of stress upon which something else happens; that is, perhaps the client is already anxious; and then an additional stress occurs, the client is overwhelmed, and responds in a negative manner.

When a client threatens harm to others, the first rule is to provide safety for yourself and the other clients. Clear the area. If talking seems to calm the client, this can be pursued, but if chairs are already flying, get out of the path and call for help. Knowing how to reach help is important. If building security is unavailable or insufficient, the local police should be contacted. It is never wise to try to subdue someone alone or with insufficient help. This increases the risk of injury and can escalate the situation. It is also unwise to underestimate the strength of even the most frail client when out of control.

A client who threatens self-harm should be taken seriously and a professional evaluation sought, especially if the person describes the manner in which he or she plans to hurt him or herself. Direct threats are not the only way a client may reveal self-injurious behavior. The client who appears to be gravely disabled is, according to mental health standards, the person who is mentally ill and unable to care for him/herself. In the case of the mentally ill and developmentally disabled, it may be someone who is living without proper supervision, is not eating, drinking, or taking proper care of hygiene, to the extent that this is life-threatening. This behavior might be the result of a delusion that all food and water is poisoned, or of voices telling him or her that s/he does not deserve sustenance and should die. Obvious physical deterioration is always a good reason to contact the program nurse or the client's doctor.

One last and, hopefully, rare emergency is the case of suspected abuse. A client who appears with an unexplained injury or other signs of maltreatment should be brought to the attention of someone in a position to assess the situation. The client's physician, advocate, or case manager may be such a person. There are protective services available for adults as well as children and this service may be indicated.

When considering a past or potential emergency, the following questions often aid understanding:

1) When did the symptoms first appear?
2) How long have they persisted?
3) Why are the symptoms appearing now?
4) Have there been changes in the home, family, work, or medical situation?
5) How available are support systems for the client? The answers to these questions help clarify any pattern that may exist potentiating helpful intervention.

One additional consideration should be made. Emergencies don't always arise from a psychosocial stressor - they may involve a medical one. For example, seizures or delirium may be accompanied by bizarre or dangerous behaviors. Because of this, conservative approaches involving medical consultation are best.

Finally, an emergency is a traumatic occurrence not only for the client, but also for the staff and other clients. Time should be available to help calm and reassure other clients. In addition, staff should have some de-briefing time of their own, a time to talk about what happened.

CONCLUSION

All effective services for people with developmental disabilities depend on informed, competent staff who work cooperatively with a wide variety of professions. Individuals with both a developmental disability and a psychiatric disorder are difficult to serve well, and no one of us has all the needed expertise. Program staff will need at least the information contained in this primer and a good working relationship with involved psychologists, psychiatrists and other health care providers.

REFERENCES

Goodman, A., Goodman, L.S. & Gilman (1980) *The Pharmacological Basis of Therapeutics.* MacMillan Publishing Co., New York.

Paul, G.L. & Lentz, R.J. (1977), *Psychosocial treatment of chronic mental patients: Milieu versus social-learning programs.* Cambridge: Harvard University Press.

Simons, R.C. (1985) *Understanding Human Behavior in Health and Illness* (3rd Edition), Williams and Wilkins, Baltimore.

Weissberg, M. (1983), *Dangerous Secrets.* New York: W.W. Norton and Company.

SUGGESTED READING

Menolascino, F.J. (1981) *Psychiatric Approaches to Mental Retardation.* Basic Books, Inc., New York

Stavrakaki, C. (1986), Psychiatric perspectives on mental retardation. *The Psychiatric Clinics of North America*, vol. 9, no. 4.